

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

31938

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (No. 2919th Newstead Ave)
 Registered No. 8963 St. 10th Ward

2. FULL NAME

Dora Princip
 (a) Residence. No. 2919th N. Newstead Ave 10 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED WIFE OF Thomas Princip
 (OR) HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1893?
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 36 | Unknown | — | — | —
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Tennessee
 (STATE OR COUNTRY)

10. NAME OF FATHER Thoms Hostler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tennessee
 (STATE OR COUNTRY)

14. INFORMANT Thomas Princip
 (Address) 2919th N. Newstead Ave

15. FILED SEP. 19 1929 May V. Parley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 3 19 29

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... 11:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gun Shot Wound Head
Self Inflicted
10 7 a. (duration), yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Suicide
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED E / 170
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. W. Turner M.D.
9/4/29 (Address) Dep. Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL Sept 5, 1929

20. UNDERTAKER Chas. J. Geraghty ADDRESS 4259 Lindell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

235

9

